Report of the Clinical Work Group: Continuity of Care (in the SMI) Advisory Panel

John Boronow, MD, (Chair), Annette Hanson (Co-Chair), Erik Roskes (DHMH staff) , Dan Martin ,Joel Kanter, Linda Raines, Jennifer Lowther, David Maina, Ann Mahling Geddes, Susan Stromberg, Lori Doyle, Ken Wireman, Louise Treherne, Robert Pitcher, Charles Gross

There were numerous enthusiastic participants from the public and other work groups at our meetings and in the Google Groups.

9/16/13

Contents

Introduction and Background

Compared with the President's *"New Freedom" Commission* & the APA's *Vision for the Mental Health System*, both in 2003, and NAMI's 2009 *Grading the States: A Vision for Transforming State Public Mental Health Services*, where are now in Maryland?

While nationally the President's Commission called America's mental health system a "shambles," Maryland has made some progress and received a "B" from NAMI in 2009. However, our work group was in complete agreement that we do not yet have a true system of care for the SMI in Maryland, and identified the following severe discontinuities in continuity of care.

Introduction and Background

The Committee requested data from MHA on a variety of characteristics, both clinical and legal, of the "high utilizer" SMI population. Unfortunately that data was not available for our work group. We believe best recommendations are data driven.

The SMI population was our focus as directed, but this was often frustrating as so many issues transcended this one group. Needs of non-SMI children and the elderly repeatedly emerged. Our task was huge, time was scarce, and this report is only an initial overview of the scope of the problem & solutions.

Members and participants were extremely knowledgeable and experienced with the wide diversity of clinical challenges and brought much wisdom as well as research literature to the discussions. The postings on our Google Group are open to the public and contain much valuable material.

Assessment of the Current State

Global Inadequacy of Outpatient Resources

- There are disproportionate resources and incentives for inpatient services
- **The system is rigged in favor of inpatient**
- This may reflect a clinical problem of so-called high utilizers
- **The 20% of consumers that take up 80% of the resources, the cost of which is mainly driven by their very frequent or long or both stays in hospitals, the most expensive treatment there is**
- It is also likely to be due to the historical reliance on hospitals until the 1970's
- **Our laws and practices have not evolved to keep up with the needs of a post-deinstitutionalized world**

Global Inadequacy of Outpatient Resources

- Global capacity of outpatient services seems to be grossly inadequate to demand
  - Evidenced by long waits for first appointments, or for appointments after being discharged from inpatient
  - The sometimes perceived over emphasis on medications may likewise reflect the lack of capacity to provide more therapists and therapies with a broader, equally evidenced base, multi-modal approach to helping people
- Transinstitutionalization of SMI to the criminal justice system
  - Too many SMI are in jails & prison for crimes driven by mental illness related behaviors

Specific Inadequacies of Outpatient Resources

By clinical populations:

• There are many clinical domains with extremely challenging patient populations that require additional expertise, resources, or administrative/legal remedies

1. Individuals in Crisis, including SMI

2. Transitional Age Youth with SMI and First Episode SMI, including silos within and between DDA, Dept of Education, MHA and commercial insurance

3. Medically ill SMI

4. Anosagnosic high risk/high utilizer SMI

Specific Inadequacies of Outpatient Resources

5.   Chemical Dependency co-morbidities in the SMI

6.   Forensic reentry for the SMI

7.   Neuropsychiatric population including TBI, epileptic, autistic spectrum, and developmentally disabled with primary SMI problems

8.   SMI with traumatic life experiences

9.   Elderly SMI

Specific Inadequacies of Outpatient Resources

By geographical location:

• There is a great, and unacceptable, disparity in availability of services and clinical expertise, by region

1. **Wealthy vs. poor**
2. **Urban vs. rural**
3. **Proximity to unique institutions (e.g. medical school, private organization, etc)**

Specific Inadequacies of Outpatient Resources

By Systems Issues:

- There is no system of care

  - This may well be true nationwide, there is no model system that we can look to simply emulate. Maryland like other states is having to create the system "by our bootstraps."

  - 60 years since the first report of chlorpromazine as an antipsychotic, deinstitutionalization has yet to create outpatient systems of care that can duplicate the integration and coordination of hospital inpatient systems

Specific Inadequacies of Outpatient Resources

By Systems Issues:

• There is poor communication of clinical information between ASO providers at all levels of care

1. **Lack of a common electronic medical record system, or alternative means to share between EMRs**
2. **Lack of a prescriber workforce that is able to coordinate care across levels of care in a timely and data informed way**

• There is not enough *clinical* data available about the SMI population for informed policy decision making

Specific Inadequacies of Outpatient Resources

By Systems Issues:

- MAH now has an historical opportunity

  - **Between 2011-12, a State of Maryland Task Force developed a major policy report, "An Integration Model for Medicaid-Financed Behavioral Health Services" which was sent to Secretary Sharfstein 10/1/12. Recommendations included:**

    - *Consolidating mental health and substance abuse services and carving them out from the rest of the Medicaid benefit, including the HealthOptions MCOs*

    - *Submitting an RFP for 2014 for the Medicaid Behavioral Health ASO that would significantly change the charge and strategic approach of the ASO, with a new "performance based" model.*

Barriers to Accessing Services Which do Exist

Social & Economic Barriers

- Even when resources and services exist, many consumers are unable to take advantage of them. Barriers include:

1. Uninsured and ineligible for any insurance
2. Uninsured and eligible, but unenrolled, including patients who are disenrolled from MA when they are hospitalized in the state hospital system
3. Insured commercially with benefits that do not cover major services such as crisis housing and PRPs

Barriers to Accessing Services Which do Exist

4. **Lack of Transportation, Childcare, and Scheduled evening and weekend hours**
5. **Homelessness, which confounds access to services even when all other entitlements and services are in place, funded and staffed**

Barriers to Accessing Services Which do Exist

<u>Disincentives to Collaborative Participation by Clients</u>

•   Many people experience the way they are treated as so alienating as to keep them away from treatment, even when services are readily available and even brought to them

1.   **Patients with a trauma history who experience treatment as repeating or exacerbating past trauma due to the lack of trauma sensitivity and training in providers and systems**

2.   **Patients who have been coercively treated and fear the possibility of it recurring and hence avoiding contact**

Global Recommendation

Global Recommendation

1) Incentivize Pay for Performance & require reinvestment of savings

- *The RFP for new ASO contract should specify Pay for Performance incentive structure for all services*
- *Require specific clinical data collection and analysis*
- *Incentivize use of more effective and cost-effective services*
- *Require reinvestment of savings into enhancing services and building capacity*

Specific Recommendations

1. Clinical
2. Administrative
3. Housing

Clinical Recommendations

2) Expand and Fundamentally Revise Crisis Services

- *Establish a statewide protocol that links the use of community crisis services with ASO emergency room/inpatient authorization policy (i.e.. ER Diversion Programs, High Inpatient Utilization/Intensive Care Management Programs)*

- *Build a 24/7 comprehensive and integrated crisis response system (adult and child) across Maryland which allows for universal access to community-based crisis and stabilization services. This system needs to align with all insurance payers in the state. See Research Recommendations below.*

Clinical Recommendations

2)   Expand and Fundamentally Revise Crisis Services

- *Explore and propose a model with a detailed budget, enabling emergency petitions to be executed to legally qualified behavioral health crisis centers instead of emergency rooms.*

Clinical Recommendations

3)   Enhance access to services for Transitional Age Youth with SMI and First Episode SMI, addressing silos separating DDA, Dept of Education, MHA and commercial insurance

- *MHA to develop a plan to specifically address inadequate capacity of community services (including RRP) for the 18-24 year old group: Suggest that this age group should be a "third age group" – not child and not adult (who need priority dx) but something different.*

- *MHA to explore legal and legislative remedies to require commercial insurances in Maryland to cover PHP services for SMI clients under 26*

Clinical Recommendations

4) Develop novel funding for Medically Ill SMI

- *Allow creative financing/reimbursement arrangements (such as capitation/case rate payments, performance incentives, etc.) that reward positive outcomes, such as reduced ED and inpatient utilization (for both somatic and behavioral health), and better health outcomes (e.g. improved labs, blood pressures) for individuals with SMI.*

- *Provide ongoing support to approved Chronic Care Health Homes to ensure that they are effective and provide the necessary fiscal savings to be sustainable over time.*

Clinical Recommendations

4) Develop novel funding for Medically Ill SMI

- *Require MCOs to work toward implementation of Collaborative Care in primary care setting. Reinvest savings into enhanced mental health programming. Expect primary care practitioners to be conversant with and compensate or otherwise incentivize them to routinely use screening tools, such as Screening, Brief Intervention, and Referral to Treatment, the PHQ-9, etc., in order to detect behavioral health issues and make referrals for specialty care as needed.*

- *Provide clear expectations of ASO to coordinate with MCOs for somatic health services and include incentives for MCOs to coordinate with ASOs without duplicating services.*

Clinical Recommendations

5) Enhance services for the anosagnosic high risk/high utilizer SMI

While there was no consensus on the specific recommendation of Outpatient Civil Commitment, there was unanimity as to the need for significantly more resources to address this population's needs in the community, as they leave the hospital & before they return to the revolving door of the emergency room and hospitalization.

Clinical Recommendations

5) Enhance services for the anosagnosic high risk/high utilizer SMI

- *Foster enhanced engagement (Unanimous Recommendation):*
  - *Develop expanded, more intensive and broader-based services without an outpatient commitment statute*
  - *Track engagement in care: Reconsider the UM Law school plan from two years ago and fund it*
  - *Enhance engagement programs including peer-run services*
  - *Provide more supervised residential care with medication administration*

Clinical Recommendations

5) Enhance services for the anosagnosic high risk/high utilizer SMI

- *Revise the Clinical Review Panel law (Unanimous Recommendation):*
  - *Address the Kelly precedent by legislation, enabling treatment of patients who are*
    - *already involuntarily committed*
    - *refusing medication*
    - *recommended to be in need of involuntary medication by a Clinical Review Panel*
    - *but not meeting the dangerousness criteria while in the protected environment of a hospital.*

Clinical Recommendations

5) Enhance services for the anosagnosic high risk/high utilizer SMI

- *Outpatient commitment (Minority Recommendation):*
  - *DHMH to propose specific Outpatient Civil Commitment policy and regulations that it could support in the upcoming session of the State Legislature*
  - *DHMH to develop a budget to realistically support the additional intensive services anticipated by the increased utilization of the this population, as well as the expected increased voluntary demand for similar services by other patients once these expanded services come on line*

Clinical Recommendations

6) Enhance Services for SMI with Chemical Dependency Co-morbidities

- *Develop specialized, dual diagnosis, crisis residential "shelters" with:*
  - *Crisis counseling*
  - *Access to a psychotropic prescriber*
  - *Case Management for concrete things like beds, food, entitlements, etc.*
  - *Ambulatory detoxification*
- *Develop "wet" shelters to accommodate homeless people who are still using*

Clinical Recommendations

6) Enhance Services for SMI with Chemical Dependency Co-morbidities

- *Develop chemical dependency services at all levels of care per the American Society of Addition Medicine*
  - *Specialty programming for SMI with chemical dependency*
  - *Evidence Based Practice trainings and certifications for chemical dependency work*
- *Achieve equity in array of services for people with CD, including residential settings*
- *Expand peer support services utilizing effectively trained and certified individuals in recovery from co-morbid substance use and mental health disorders*

Clinical Recommendations

7)   Enhance Services for Community Re-entry of SMI with forensic history

- *Modify time to determine unrestorability. National Judicial College suggests the following limits:*

  - **4 months for misdemeanors**

  - **1 year for felonies**

- *Re-establish Hamilton House or equivalent transitional and permanent supportive housing programming for forensic patients*

Clinical Recommendations

7) Enhance Services for Community Re-entry of SMI with forensic history

- *Continuously fund and expand inreach release planning b/w DPSCS and DHMH & include county detention centers in this model. Implement improvements to the model to ensure that patients will be able to follow up with treatment when released.*

- *Adequately resource programs to assist people leaving prison including support for employment services.*

Clinical Recommendations

7) Enhance Services for Community Re-entry of SMI with forensic history

- *Expand mental health P&P specialization*
- *Training and education of community providers to competently manage (and deal with reporting requirements and liability concerns attendant to) working with forensic pts (agency liaison program?)*
- *$$$$$$$ resources needed.*

Clinical Recommendations

7) Enhance Services for Community Re-entry of SMI with forensic history

- *Better communication between forensic and community systems of care*

- *Modify law requiring community service plan as condition of discharge for IST defendants in regional hospitals*

- *With the affordable care act, resources need to be put into enrolling people in Medicaid upon release.*

- *Ensure that newly adopted information and data collection systems facilitate sharing of information between health, social service and corrections while incorporating privacy protections.*

Clinical Recommendations

7) Enhance Services for Community Re-entry of SMI with forensic history

- *Fund and implement Medicaid computer systems that allow for full implementation of the policy to suspend and not terminate benefits while individuals are incarcerated.*

- *Submit a State Plan Amendment(SPA) to allow pre-trial detainees to receive Medicaid while incarcerated (as now permitted under the ACA)*

Clinical Recommendations

8) Address specific service gaps for the neuropsychiatric population including TBI, epileptic, autistic spectrum, and developmentally disabled with primary SMI problems

- *Funding of additional specialized crisis residential services for neuropsychiatric patients coming out of inpatient settings who are unable to return home or to previous providers*
- *There is a need for better cross-system integration (MH/DD/TBI)*

Clinical Recommendations

9) Provide training to all providers in trauma based skills

- *Enhance awareness of trauma in the lives of SMI patients, especially in the Chemically Dependent and Forensic groups.*

- *Develop skills training programs to address trauma diagnosis and treatment competencies*

Clinical Recommendations

10) Enhance Services to Elderly SMI

- *Identify the extent of unmet needs and the barriers to service delivery in this population, including*

  - **Waivers and increased funding for non-nursing home care including assisted living and in-home supports to serve elderly with behavioral health concerns**

  - **Substance use disorder services for the elderly that are not covered by Medicare (while advocating for better Medicare coverage**

Clinical Recommendations

11) Confront the regional disparities in services to the SMI

- *The state and the CSAs will acknowledge the reality of the problem and develop short term administrative solutions that facilitate making services – including inpatient care – more accessible to people living in rural areas*

- *Address workforce shortages in under served areas*

- *Support funding and expansion of telemedicine*

Administrative Recommendations

12) Short term *services integration* improvements

- *Develop fee-for-service CPT codes and fee schedules to allow outpatient providers to:*
  - **Physically meet (and build connections) with consumers on IP units, prior to D/C**
  - **Provide non-face-to-face, coordination of care and case management services**
  - **Allow Medicaid billing for collaborative care meetings between BH and somatic practitioners such as implemented by the Cherokee Health Systems in Tennessee.**

Administrative Recommendations

12) Short term *services integration* improvements

- **Create a systemic process for securing a Release of Information when entering the public health system (initial Medicaid eligibility) for coordination of care between the Somatic, SA and MH providers**
  - **Search all 50 states to determine where state law has most efficiently reduced the barriers to ROI and coordination of care between providers and also families**
- **Propose draft legislation emulating these laws if there is consensus as to value of such changes in the law**

Administrative Recommendations

12) Short term *services integration* improvements

- *Search all 50 states for a best practice to enhance the enforceability of Psychiatric Advanced Directives (PADs), including Ulysses clause and mandatory waiting period before revocation*
- *Propose draft legislation emulating these laws if there is consensus as to value of such changes in the law*

Administrative Recommendations

13) Short term *access to care* improvements

- *Search all 50 states for a best practice to facilitate rapid enrollment in Medicaid*
  - **Propose specific recommendations to emulate nationally recognized best practices in Medicaid enrollment, including simplification of the application process and documentation to the extent possible**
  - **Establish target standards for time to enrollment from initial application to availability of services**
- *Facilitate and enhance enrollment in Medicaid or the health benefit exchange of all people exiting incarceration.*

Administrative Recommendations

13) Short term *access to care* improvements

- *Explore legal or legislative remedies to address the refusal of commercial insurance companies to honor their parity obligations to provide* crisis residential housing *as part of their benefit package*

- *Identify and act upon patient-related factors that deter voluntary participation in care by making patient experience surveys meaningful (anonymized aggregate data sent to centralized location). (Consumer Quality Team could play a role in this, as they already are engaged in this activity in the PMHS.)*

Administrative Recommendations

13) Short term *work force expansion* improvements

- *Align professional licensing requirements with educational offerings*

- *Compare and adjust reimbursement requirements and rates for all behavioral health professional categories, including mental health, substance use disorder, and other categories of providers*

- *Allow for reimbursement for programs utilizing certified non-licensed professionals, board approved trainees, paraprofessionals and peer-specialists under supervision of licensed professionals*

Housing Recommendations

14) Increase supervised residential care for the SMI

- *Provide more housing options to service individuals with more intensive needs*
  - **Target 1: all identified high risk patients would have access to housing within 30 days of entry into a Crisis Residential program**
  - **Target 2: all approved applications for Residential Rehabilitation Programs would have access to such housing within 90 days of application**
- *Reduce licensing barriers for assisted living providers to providing services to people with mental illnesses while ensuring quality.*

Appendix

Longer Term Research and Development Recommendations

Research Recommendations

- There was unanimous concern that too many of the problems identified above represented challenges for which there are still no agreed upon solutions.

- The Work Group expresses its full enhanced support for funding clinical services research, and to integrating the superb resources at the University of Maryland with our service delivery system.

Research Recommendations

- Enhance currently available clinical data reports about MA patients
  - **Publically document currently available anonymized and aggregated data elements**
    - **Disseminate reports already available**
  - **Solicit suggestions from clinicians as to additional reports**
    - **Explore ways to collect and integrate additional data elements around EPs, certificates, certificates converted to voluntary, certificates going to commitment hearings and outcome, Clinical Review Panels and their appeal hearings.**

Research Recommendations

- Explore feasibility of creating demonstration pilot centralized psychiatric "Entry Points" in metro Baltimore based on CIT and CPEP and other similar models, with
  - **24/7 single point of entry**
  - **Not collocated with hospitals**
  - **Legally empowered to do Emergency Petition assessments**
  - **Staffed and equipped to handle violent patients**
  - **72 hour observation capability**
  - **Funded to incentivize hospital diversion**
  - **Deeply integrated with all metro MA services**

Research Recommendations

- Explore avenues to integrate clinical data sharing and access across all levels of care
  - *The ASO contract will explicitly commit to studying and recommending by 2015:*
    - **Clinical electronic medical record solutions across all outpatient levels of care (excluding partial)**
    - **Specific performance expectations of prescribers regarding their timely availability for the coordination of data informed care across levels of care**

Research Recommendations

- Workforce expansion
  - *Recommend a program to allow partial or full loan forgiveness to recent trainees who commit to underserved areas (recommendation also made by sex offender advisory board facing identical problem)*
  - *Support loan repayment incentive programs more generally for people to enter the behavioral health professions at large*
  - *Research and define the extent of need for additional culturally competent translation services*

Research Recommendations

- Systematically optimize alignment of payers for the SMI
  - **Coordinate Medicaid covered services with state and federal grant funded services**
  - **Ensure parity of services between Medicaid services and Health benefit Exchange service**
  - **Ensure that coverage in Medicaid and the health exchange are aligned and facilitate providers in both networks to support continuity of care for those moving between the exchange and Medicaid.**
  - **Ensure that all behavioral health services are covered and that all levels of care for mental health and substance use disorder services are accessible**

Research Recommendations

- Explore the expansion of mental health courts in Maryland

Now is the time to step forward and bring treatment to all those who need it.